

**HEALTH HISTORY AND REGISTRATION-ADULT**

Today's Date \_\_\_\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_ Sex: M F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_ Years employed: \_\_\_\_\_  
General Dentist: \_\_\_\_\_ Marital Status: Married Divorced Separated Single Widowed  
Other family members seen by us: \_\_\_\_\_  
Spouse name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Ext: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone#: \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Driver's License#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_

**DENTAL INSURANCE**

Orthodontic Coverage? Yes No  
Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insurance Company Phone #: \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured's Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Employer: \_\_\_\_\_

**DENTAL HISTORY**

What are the main orthodontic concerns? \_\_\_\_\_  
Have you ever been evaluated or had orthodontic treatment before? \_\_\_\_\_  
Has there been any injuries to the face, mouth, teeth, or chin? \_\_\_\_\_  
Have you ever had a serious/difficult problem associated with any previous dental work?: \_\_\_\_\_  
**Do you now or have you ever experienced pain/discomfort in your jaw joints (TMD)?** \_\_\_\_\_  
Do you have any missing or extra permanent teeth? \_\_\_\_\_  
Do you have any speech problems? \_\_\_\_\_ Do your gums ever bleed? \_\_\_\_\_  
Do you generally breathe through your mouth or nose? \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_ Were the teeth cleaned? \_\_\_\_\_

**MEDICAL HISTORY**

Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Please list all drugs you are currently taking: \_\_\_\_\_  
**Circle any/all that you have an allergy to:** Penicillin Aspirin Erythromycin Tetracycline Codeine Latex Dental  
Anesthetics Any metal/plastic Other \_\_\_\_\_  
**Circle if you have or had any of the following:** Heart Murmur Cancer Diabetes Rheumatic Fever  
HIV+/AIDS Hemophilia Asthma Hepatitis Tuberculosis Congenital heart defect Abnormal bleeding  
Convulsions/epilepsy Heart attack/Stroke Kidney/liver problems Handicaps/disabilities Surgeries  
Heart surgery/Pacemaker Shingles Mitral valve prolapse Artificial bones/joints Sinus problems  
Psychiatric problems High/low blood pressure Fever blisters Severe/frequent headaches Arthritis  
Drug/alcohol abuse Venereal disease Ulcers/colitis Difficulty breathing blood transfusion Emphysema  
If "yes" to any, please explain \_\_\_\_\_  
Do you need pre-medication for dental procedures? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_  
Do you smoke or use tobacco? \_\_\_\_\_

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during diagnosis and treatment. This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all orthodontic fees. I also assign all insurance benefits to the Doctor. All payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the orthodontic fees incurred.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Dr.'s Signature \_\_\_\_\_